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"Environmental contamination occurs in the rooms of 73% of infected patients and 69% of colonized patients.."

WiscRisk
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MRSA on the Move

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Part 2 presents the core elements and key considerations for implementing an effective policy in a variety of settings. In addition part 2 addresses resource considerations regarding the successful implementation and use of a MRSA and infection control policy.

Risk View

Communicating and following up on findings Controlled Risk Insurance Company (CRICO), which provides professional liability insurance to the Harvard medical institutions, has identified inadequate communication as the second most frequent risk management issue - following clinical judgment - for open and closed claims made from 1995 through 1999. While the need to communicate changes in condition with multiple providers is not unique to LTCFs, what is unique is that it is expected that LTC residents will have underlying diseases, some significant, that are not expected to improve. The pervasive trend to make long term care facilities appear home-like rather than clinical, combined with the fact that for long-term care residents the facility becomes their home; the need for criteria to identify residents at risk for MRSA infections must be considered.

In the case, there was no evidence of direct communication between providers regarding the wound drainage (amount, color, odor) and the initial negative culture results. Staff interviews revealed that it was common practice to document daily skin inspections and to notify physicians when a significant change was noticed. This facility also had a practice of filing negative lab results in the resident's record prior to physician review. In this case, the patient arrived at the LTCF for rehabilitation services with a surgical wound. As wound drainage was noted on admission, continued drainage was not considered a significant change. This patient also had a history of chronic UTIs treated with antibiotic therapy. This should have heightened staff and providers' concern regarding the potential for a MRSA infection in this resident.

A patient's hospital stay on average after surgery is four to five days; so many MRSA infections are not diagnosed until after discharge. The literature supports that elderly residents are at increased risk for colonization with MRSA, in addition to having the potential to carry MRSA for long periods of time.

A principle of complex systems is that standardization improves function. LTCFs should have a process that stresses the need for direct communication between professional staff about medical management, clinical observations, and diagnostic results. The process should consider these points:

- Priority should be given to maintaining safe, quality resident-care.
- Direct discussions among involved parties regarding clinical observations and changes or lack of change in condition should be encouraged.
- If the involved parties cannot resolve differences in clinical opinion, they should seek assistance in resolving the discord through medical, nursing hierarchy.
- All discussions pertaining to differences in clinical opinion should occur among professional staff only and out of earshot of the patient and family.
- Differences in clinical observations and opinions should be reported to the LTCF risk manager.
- Unexpected incidents relating to the resident should be reported to the LTCF risk manager.

In the case, an earlier diagnosis of MRSA might have been made with the development of a mechanism for direct communication between professionals regarding a discord in resident's clinical observations and diagnostic results needing to be further investigated.

Providing Appropriate Resources

As was mentioned earlier, a number of factors attribute to the persistence of antimicrobial-resistant bacteria in LTCFs. While factors such as residents' underlying diseases, indwelling foreign bodies (urinary catheters, feeding tubes, tracheostomies, etc) and communal activities such as meals and various types of therapy increase the likelihood of person-to-person transmission, hands of staff appear to be the most likely mode of transmission of MRSA from patient to patient. LTCFs need to educate, train and enforce staff adherence to standard infection-control protocol.

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About WiscRisk

WiscRisk is published quarterly and circulated to more than 12,000 healthcare providers statewide. Designed to keep readers informed of trends in liability claims and loss prevention, this publication is prepared by the Risk Management Steering Committee for the Injured Patients & Families Compensation Fund.

MRSA on the move - Continued

Protocols should require that gloves be worn when providing care that involves substantial personal contact or contact with items that may be contaminated by MRSA. For staff this should include wearing gloves when performing routine resident-care, including changing clothes, assisting to/from toilets, assisting with bathing, and changing bedding. A 1997 MRSA survey reported environmental contamination occurred in the rooms of 73% of infected patients and 69% of colonized patients. Frequently contaminated objects included the floor, bed linens, the patient's gown, overbed tables, and blood pressure cuffs.

Staff should be encouraged to wear gowns any time the caregiver's clothing is likely to have contact with a MRSA-positive resident during the course of care. The challenge is that not all MRSA-positive residents have clinical signs and symptoms of infection. Gowns should be worn for activities such as lifting and when giving bed baths, but are not necessary for activities such as feeding or taking vital signs. Gown and gloves should be worn by staff when stripping beds, and soiled lines should be bagged in the resident's room.

Hand washing with antibacterial soap cannot be over emphasized as an effective infection-control mechanism. Staff and visitors should be instructed to wash their hands after glove removal, after patient care, and prior to leaving the room of a MRSA-positive resident. Some facilities have seen increased compliance with hand washing through the use of the waterless, alcohol-based hand antiseptics.

Another important fact that was undervalued upon admission to the long-term care facility was the patient's wound drainage. Review of documentation reveals that staff identified the drainage and communicated with the primary care physician regarding wound care. However, there was no process in place at the LTCF to identify this patient as being at high risk for MRSA infection. The importance of staff education regarding MRSA and infection control in general cannot be over emphasized. All staff working in healthcare facilities, acute care, or long term care, should receive education and training regarding MRSA, the importance of control, and the potential risk of cross-contamination between treating facilities. Education should be provided on a regular basis - at least annually - and each facility should have someone responsible for the facility-wide infection-control program. The case illustrates the importance of developing and implementing MRSA - and infection control in general.

Continuous Patient Safety Education

The WI Injured Patients and Family Compensation Fund is proud to announce a continuous education cycle of Patient Safety Strategies. Key patient safety issues to be reviewed include:

- Infection Control
- Disclosure
- Telephone Advice
- Safe Patient Environment
- Documentation
- Medication Errors
- Risk Management for the Physician Office

First, each covered Patient Safety issue of the education cycle will be highlighted in the quarterly WiscRisk newsletter. Second, Self-audit tools will be posted on the **www.oci.wi/gov/pcf.htm** website.

Third, after your Self-audit is completed, you can access the live telephone consultation and web-based resources for improvement strategies. Finally, the web-based audit tool and resources will remain available and updated to serve you as a tool for continuous improvement.

Issues of previous newsletters are available on the following website: **www.oci.wi.gov/pcf.htm**

MRSA Infection Control Self Audit

		Circle One	
1.	Do you have a written infection control program?	Yes	No
2.	Is an individual designated to coordinate the infection control program?	Yes	No
3.	Are the basic elements of an infection control program in place:		
	a. Prevention	Yes	No
	b. Surveillance	Yes	No
	c. Control measures	Yes	No
4.	Does your staff pre-employment process include vaccination / screening?	Yes	No
5.	Does your staff orientation process include:		
	a. Hand washing	Yes	No
	b. Universal precautions	Yes	No
	c. Infectious waste management	Yes	No
	d. Cleaning guidelines	Yes	No
6.	Do you identify patients at risk for MRSA infection and potential colonization?	Yes	No
7.	Have you established criteria to identify patients at risk for MRSA infections?	Yes	No
8.	Have you established criteria to identify patients at risk for MRSA colonization?	Yes	No
9.	Do you communicate a patients MRSA status to other care providers upon admission to Long-term Care or Acute Care facilities?	Yes	No
10.	Do you, to the extent possible, isolate MRSA infected residents?	Yes	No
11.	Are waterless alcohol-based hand antiseptics in all patient rooms?	Yes	No
12.	Do you have written policies and procedures for:		
	a. Hand washing	Yes	No
	b. Communication between providers regarding wound drainage and initial negative cultures	Yes	No
	c. Use of gloves, protective clothing and other personal protective equipment	Yes	No

Questions Call 1-800-606-4193